EDITORIALS

Participatory Democracy and Health Care

IT WAS ONLY a decade or so ago when the government planners for health care seemed to be firmly in the saddle. It seemed to be a heyday for attempting to find national solutions to national social problems, including health care. Equal access to the vote, affirmed by the famous one man one vote decision of the United States Supreme Court, strengthened the expectations of many for equal access to everything else, and again this included health care. The now all too familiar series of federal "initiatives," as the government likes to call them, came into being and continue until this day. For a while it appeared that the majority, led by federal planners who had in mind what they thought would be best for everybody, might ride roughshod over those with minority views, or even over an individual person's right to be different or to place a different value on what might be best for him or her. There was comparatively little direct public participation in planning or the decision making processes. But this was more than a decade ago.

In the late 1960's a countervailing force came upon the scene. A deep and widespread revolt against authority developed among college students and the younger generation which was reaching maturity at that time. They declined to be passively absorbed into the establishment, emphasized their right to be different and to find their own individual personal fulfillment in their own way. They espoused the causes of minorities of all kinds and demanded to be part of planning and decisions which affected them. At first the effects of this were upon colleges and universities, and they were profound. But now its impact is beginning to be felt in many other aspects of today's society. In health care, for example, a physician's authority is much less likely to be taken at face value, the effectiveness of much that was thought to be scientific medicine is being questioned, and we are beginning to see a substantial interest in many alternative and less scientific methods of care and treatment which would have received scant attention as recently as the early 1960's.

It would seem, therefore, that two things are happening. The federal initiatives in health have not been as effective as the planners had expected and the impetus for centralized federal control of health care is diminishing as the costs rise, while the public demand for more direct participation in planning and decisions which affect them is increasing substantially. If these trends continue, and they continue to focus on health care as seems likely, a new era of participatory democracy for planning and decision making in this field may be beginning. Indeed this seems to be the case. Informed consent already has made participatory democracy a reality in the care of patients, and the Health System Agencies (HSA's) are now making it a reality for planning and decision making for health and health care for local communities.

All of this suggests an important change in the ways physicians can be most effective. Instead of giving orders on the assumption they will be followed or making public pronouncements on the presumption that they will be accepted without question, it is now becoming necessary for physicians to bring their professional expertise to bear in other ways. However, what is needed is really nothing new. Rather it foreshadows a renaissance and a further refinement of the age-old function of physicians to help and to teach. Physicians can uniquely give authoritative information about health and its disorders; what is wrong, what is likely to happen and what can be done about it. And when they act as consultants, advisers and teachers—whether of patients or the public generally—they can be effective indeed as peer par-

ticipants in the planning and decisions for health care at the patient, community or national level. It now behooves physicians and the medical profession to spend the time necessary and develop the skills needed to participate fully in this new participatory democracy which has become such an important part of medicine and health care in the society we serve.

—MSMW

Adult Respiratory Distress Syndrome

What To Do Until the Basic Scientist Comes

THE CLINICAL MANIFESTATIONS of diffuse injury to the lung parenchyma vary from fulminant pulmonary edema that may be rapidly fatal to the much more indolent pulmonary fibrosis causing chronic abnormalities of gas exchange, disability and death in some cases. The determinants of the response of the lung to a given injury are unknown and, perhaps more important, the mechanisms by which the injury is delivered are obscure. However, in the past eight to ten years there has been considerable elucidation and definition of the effects of the acute form of lung injury on pulmonary function, and as a consequence of this understanding, more effective approaches to therapy have been developed.

The review of what, for want of a better term, is called the adult respiratory distress syndrome (ARDS) by Petty and Newman in this issue of the WESTERN JOURNAL discusses the development of concepts regarding this form of respiratory failure and presents current ideas as to pathogenesis, prevention and treatment. As with other reviews[1,2] of the topic, the present article raises more questions than it answers (an important function of a review article).

One of the more important current questions concerns terminology. The obvious imprecision of the designation ARDS has been discussed previously.[3,4] As noted by Petty and Newman, the lack of general acceptance of this term is apparent by the extraordinary number of synonyms used. Because of a lack of accepted, precisely defined terminology, it is difficult to develop information concerning incidence, natural history and response to therapy. Cooperative studies that attempt to examine any but the most flagrant examples of this form of respiratory insufficiency are doomed to failure because of the inability to define adequately what constitutes the study population. Nevertheless, the catchall term ARDS has been used widely and frequently enough so that it does, in the minds of most physicians, conjure an image of a form of respiratory failure that is quite different from the other common form of respiratory failure—that caused by airway obstruction. For this reason the continued use of the term is of some value, assuming that when specific causes are identified, they will be removed from the ARDS "wastebasket" and treated as separate entities. A good analogy is the clinical and pathophysiologic complex called "heart failure." A diagnostic evaluation does not end when it is determined that heart failure is present; there is an obligation to find the cause of the heart failure by as complete an examination as is necessary and available. The same philosophy should apply to the patient who is considered to have ARDS.

A whole set of complicated interrelated questions concerning prevention and treatment derive from our lack of knowledge concerning basic mechanisms of injury. It is obvious from reading the "Theories of Pathogenesis" section, and Table 3, in the Petty-Newman paper that many mechanisms alone or in combination are involved. Were we able to identify specific mechanisms in individual patients, then specific therapy could be applied. Theoretic arguments can be raised for the use of corticosteroids and heparin as well as several other agents. However, it has yet to be shown convincingly that any of these compounds has a beneficial effect in patients with ARDS. Here, the problems of imprecise terminology and lack of knowledge of basic mechanisms pose major stumbling blocks. The mechanisms by which acute lung injury occurs were the subject of a recent National Heart, Lung, and Blood Institute workshop that was designed to identify specific research needs.[5] Although the direction provided by this workshop, as well as research currently underway in many centers, certainly holds promise, it appears that we are still several years away from clinically applicable information concerning basic mechanisms. Therefore, for the time being we must be content to treat with supportive rather than curative measures.

We do know that once the lung injury has occurred, the ensuing sequence of events is quite similar regardless of the cause. As Petty and New-